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Amboy's In-Retirement Learning Center
HEALTH

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Healthcare in Retirement

What health care benefits are available in retirement?

Health care in retirement is available from many sources. Government programs (such as Medicaid and Medicare) offer numerous health care benefits. However, you may need to purchase supplemental health insurance or Medigap, as well. Most Americans are eligible to begin receiving Medicare benefits at age 65, but qualifying for Medicaid may require some planning on your part. In addition to these resources, you may also be entitled to military health care benefits if you are a veteran, retired servicemember, or the spouse or widow of a veteran or retired servicemember. Continuing care retirement communities and nursing homes also offer health care services for older individuals. Depending on your specific needs and circumstances, you may use any number of these resources during your retirement years.

Medicare

In general

Medicare is a federal health insurance program created in 1965. Medicare primarily assists those who are 65 or older, but if you are disabled or have kidney disease, you may be eligible for Medicare coverage no matter what your age. Medicare currently consists of Part A (hospital insurance), Part B (medical insurance), Part C (which allows private insurance companies to offer Medicare benefits), and Part D (which covers the costs of prescription drugs), with each part having its own eligibility requirements. You may qualify for one or more parts, or you may choose to accept or decline coverage if you are eligible. Many health policies limit coverage for Medicare-eligible individuals regardless of whether they have accepted Medicare coverage.

Medicare benefits for disabled individuals

Under certain conditions, the disabled are eligible to enroll in Medicare before age 65. If you have been receiving (or have been entitled to receive) Social Security disability benefits for at least 24 months (not necessarily consecutively), you may be eligible to enroll in Medicare. To enroll, you must be entitled to benefits in one of the following categories:

- A disabled individual of any age receiving worker's disability benefits
- A disabled widow or widower age 50 or older
- A disabled beneficiary who is older than age 18 and receives benefits based on a disability that occurred before age 22

In addition, Medicare may be available at any age if you are disabled as a result of chronic kidney failure requiring dialysis or a kidney transplant.

Qualified Medicare Beneficiary program

If you have limited means, you may be eligible for the Qualified Medicare Beneficiary (QMB) program. Here, your state's Medicaid program may pay for your Medicare Part B premium, Part A and Part B deductibles, and coinsurance requirements. Eligibility rules may vary from state to state, but in general, you must meet the following three criteria:

- You must be entitled to Medicare Part A
- Your income must be at or below the national poverty level
- The value of your assets must be below a certain level

There are also other related programs that have somewhat less restrictive eligibility requirements.

Medigap

In general

Medigap is supplemental insurance specifically designed to cover some of the gaps in Medicare coverage. Although the name might lead you to believe otherwise, Medigap is provided by private health insurance companies, not the government. However, Medigap is strictly regulated by the federal government.

There are 10 standard Medigap policies available (Plans E, H, I, and J are no longer available for sale, however, if you already have one of these plans you can keep that plan). All plans may not be offered in your state, yet all are standardized and certified by the U.S. Department of Health and Human Services so that each plan provides exactly the same kind of coverage no matter what state you live in (except for Massachusetts, Minnesota, and Wisconsin, which have their own standardized plans). Every Medigap policy offers certain basic core benefits, such as coverage of certain Medicare Part A and B coinsurance and co-payments. Other plans offer additional benefits, such as coverage of Medicare Part A and B deductibles, and charges that result when a provider bills more than the Medicare-approved amount for a service.

Medicaid

In general

Medicaid provides medical assistance to aged, disabled, or blind individuals, or to needy, dependent children who could not otherwise afford the necessary medical care. Medicaid pays for a number of medical costs, including hospital bills, physician services, home health care, and long-term nursing home care. Each state administers its own Medicaid programs based on broad federal guidelines and regulations. Within these guidelines, each state performs the following: (1) determines its own eligibility requirements; (2) prescribes the amount, duration, and types of services; (3) chooses the rate of reimbursement for services; and (4) oversees its own program.

Applying for benefits

To apply for Medicaid, you must use a written application on a form prescribed by your state and signed under penalties of perjury. Give the application to your state Medicaid office. Typically, you will need to provide proof of age, marital status, residence, and citizenship, along with your Social Security number, verification of receipt of government benefits, and verification of your income and assets. A responsible individual can complete the application on behalf of an incompetent or incapacitated individual.

Eligibility

To qualify for Medicaid, you must meet two basic eligibility requirements. First, you must be considered categorically needy because of blindness, disability, old age, or by virtue of being the parent of a minor child. Next, you must be financially needy, which is determined by income and asset limitation tests. States have much discretion in determining which groups their Medicaid programs will cover, but as participants in Medicaid, they must provide coverage for all residents who are considered categorically needy.

Caution: *State and federal rules regarding Medicaid eligibility change frequently.*

Transfer of assets

Because Medicaid eligibility is based on your income and other resources, state Medicaid authorities are interested in knowing whether you have tried to transfer assets out of your name in order to qualify for Medicaid. When you apply for Medicaid, the state has the right to examine your finances and those of your spouse as far back as 60 months from the date you are eligible for medical assistance under the State plan. Only certain transfers are prohibited. Fair market transactions will typically be considered legitimate, but if you transfer assets for less than fair market value around the time you apply for Medicaid, the state will presume that the transfer was made solely to help you qualify for Medicaid.

Planning goals and strategies

As mentioned earlier, the state has the right to look into your financial transactions to determine whether you have transferred assets solely to qualify for Medicaid. However, the state may count only the income and assets that are legally available to you for paying your bills. Consequently, several methods have been developed to help you shelter your assets from the state and facilitate Medicaid qualification. Proper planning can help you to qualify for Medicaid, shelter "countable" assets, preserve assets (including the family home) for loved ones, and protect the healthy spouse (if any).

Medicaid qualifying trusts

To qualify for Medicaid, both your income and the value of your other assets must fall below certain limits (which vary from state to state). A trust helps you to qualify for Medicaid because it can shelter your income and assets, making them unavailable to you. The state Medicaid authorities cannot consider assets that are truly inaccessible to the Medicaid applicant. Therefore, anything

that stays in an irrevocable trust will lie outside of your financial picture for Medicaid eligibility purposes. If you are looking for a strategy to shelter your resources, one of the following may be appropriate: (1) an irrevocable income-only trust, (2) an irrevocable trust in which the creator of the trust is not a beneficiary, (3) a Miller trust, or (4) a special needs trust.

Protection of principal residence

In certain cases, the state may be entitled to seek reimbursement for Medicaid payments by forcing the sale of your principal residence if you are a Medicaid recipient. Medicaid planning tools have been devised to protect your home, but their effectiveness varies. Therefore, it is important to weigh the costs and benefits of each device carefully. If you are looking for a strategy to preserve your home for loved ones, one of the following four methods may be appropriate: (1) an outright transfer or gift of the home, (2) a transfer subject to life estate, (3) a transfer subject to special power of appointment, or (4) a transfer in trust.

Medicaid and long-term care insurance

Long-term care (LTC) insurance can be useful as part of your Medicaid planning strategy. Your LTC policy can subsidize your nursing home bills during the Medicaid ineligibility period caused by your transfer of assets to third parties. Thus, it may be possible for you to give your assets away to loved ones, have the security of paid nursing home bills during the ineligibility period, and qualify for Medicaid when the LTC policy runs out.

Medicaid liens and estate recoveries

Federal law requires states to seek reimbursement from Medicaid recipients for Medicaid payments made on their behalf. Cost-recovery actions against the assets of Medicaid recipients may come in two forms: (1) real or personal property liens and (2) recovery from decedents' estates. A Medicaid lien makes it impossible for you to sell or refinance your house without the state's knowledge and ability to collect what it is owed. As for recovery from decedents' estates, states also can seek reimbursement from your probate estate after you die. States have the option to expand the definition of estate to include all nonprobate assets as well.

Divorce and Medicaid

From a purely financial perspective, divorce can be a practical move and may actually be used as a Medicaid planning tool. When a spouse enters a nursing home and applies for Medicaid, the couple's assets must be pooled together and totaled to determine what portion the healthy spouse may keep. After this Spousal Resource Allowance has been determined, the Medicaid applicant must transfer assets representing the amount of the allowance to the healthy spouse. The remaining assets must be spent on the institutionalized partner's medical care. A divorce court order can supersede the normal Spousal Resource Allowance rules prescribed under state Medicaid regulations. You should consult your legal advisor for further information.

Military benefits

Disability benefits, health-care benefits, and long-term care benefits are available through various military programs sponsored by the Department of Defense and the Department of Veterans Affairs (VA), formerly known as the Veterans Administration. Health care for veterans is typically available at VA hospitals and health-care facilities. In general, active service members, retirees, and veterans other than those who were dishonorably discharged are eligible for military benefits. Survivors of servicemembers and veterans are also generally eligible for some of the same benefits. However, the rules surrounding these benefits can be complex and may change frequently. It is best to check with your military personnel office or local VA office if you have questions about any of these benefits.

Choosing a continuing care retirement community

Continuing care retirement communities (CCRCs) are retirement facilities that offer housing, meals, activities, and health care to their residents. These communities appeal to people who are currently in good health but who worry that they may need nursing care later on. The CCRC and the resident sign a contract guaranteeing that the CCRC will provide housing and nursing home care throughout the resident's life and that, in return, the resident pays an entrance fee and a monthly fee. In choosing a CCRC, you should consider factors such as the entrance fee and monthly fees, insurance requirements, the financial stability of the CCRC, its facilities and activities, and the quality of medical care provided to residents.

Choosing a nursing home

A nursing home is a licensed facility that provides skilled nursing care, intermediate care, and custodial care. Although you may prefer in-home care, you may have to enter a nursing home if you need round-the-clock care, especially if you can't get help from family or an in-home caregiver. When choosing a nursing home, you should consider factors such as the cost of the home, the quality of medical care provided, the appearance and the safety of the facilities, the ratio of staff to residents, and recreational opportunities.

Paying for nursing home care

Nursing home care can be extremely expensive, and paying for this care is a problem that weighs heavily on the minds of older Americans and their families. There are several resources you can use in planning for this expense, including self-insurance, long-term care insurance, Medicare (limited benefits), Medicaid, and military benefits.

Medicaid Planning Basics

The best time to plan for the possibility of nursing home care is when you're still healthy. By doing so, you may be able to pay for your long-term care and preserve assets for your loved ones. How? Through Medicaid planning.

Eligibility for Medicaid depends on your state's asset and income-level requirements

Medicaid is a joint federal-state program that provides medical assistance to various low-income individuals, including those who are aged (i.e., 65 or older), disabled, or blind. It is the single largest payer of nursing home bills in America and is the last resort for people who have no other way to finance their long-term care. Although Medicaid eligibility rules vary from state to state, federal minimum standards and guidelines must be observed.

In addition to you meeting your state's medical and functional criteria for nursing home care, your assets and monthly income must each fall below certain levels if you are to qualify for Medicaid. However, several assets (which may include your family home) and a certain amount of income may be exempt or not counted.

Medicaid planning can help you meet your state's requirements

To determine whether you qualify for Medicaid, your state may count only the income and assets that are legally available to you for paying bills. That's where Medicaid planning comes in. Over the years, a number of tools and strategies have arisen that might help you qualify for Medicaid sooner.

In general, Medicaid planning seeks to accomplish the following goals:

- Exchanging countable assets for exempt assets to help you meet Medicaid eligibility requirements
- Preserving assets for your loved ones
- Providing for your healthy spouse (if you're married)

Let's look at these in turn.

You may be able to exchange countable assets for exempt assets

Countable assets are those that are not exempt by state law or otherwise made inaccessible to the state for Medicaid purposes. The total value of your countable assets (together with your countable income) will determine your eligibility for Medicaid. Under federal guidelines, each state compiles a list of exempt assets. Usually, this list includes such items as the family home (regardless of value), prepaid burial plots and contracts, one automobile, and term life insurance.

Through Medicaid planning, you may be able to rearrange your finances so that countable assets are exchanged for exempt

assets or otherwise made inaccessible to the state. For example, you may be able to pay off the mortgage on your family home, make home improvements and repairs, pay off your debts, purchase a car for your healthy spouse, and prepay burial expenses.

For more information on this topic, contact an elder law attorney who is experienced with your state's Medicaid laws.

Irrevocable trusts can help you leave something for your loved ones

Why not simply liquidate all of your assets to pay for your nursing home care? After all, Medicaid will eventually kick in (in most states) once you've exhausted your personal resources. The reason is simple: You want to assist your loved ones financially.

There are many ways to potentially preserve assets for your loved ones. One way is to use an irrevocable trust. (It's irrevocable in the sense that you can't later change its terms or decide to end it.) Property placed in an irrevocable trust will be excluded from your financial picture, for Medicaid purposes. If you name a proper beneficiary, the principal that you deposit into the trust (and possibly any income generated) will be sheltered from the state and can be preserved for your heirs. Typically, though, the trust must be in place and funded for a specific period of time for this strategy to be an effective Medicaid planning tool.

For information about Medicaid planning trusts, consult an experienced attorney.

If you're married, an annuity can help you provide for your healthy spouse

Nursing homes are expensive. If you must go to one, will your spouse have enough money to live on? With a little planning, the answer is yes. Here's how Medicaid affects a married couple. A couple's assets are pooled together when the state is considering the eligibility of one spouse for Medicaid. The healthy spouse is entitled to keep a spousal resource allowance that generally amounts to one-half of the assets. This may not amount to much money over the long term.

A healthy spouse may want to use jointly owned, countable assets to buy a single premium immediate annuity to benefit himself or herself. Converting countable assets into an income stream is a plus because each spouse is entitled to keep all of his or her own income, in contrast to the pooling of assets. By purchasing an immediate annuity in this manner, the institutionalized spouse can more easily qualify for Medicaid, and the healthy spouse can enjoy a higher standard of living.

Be aware, however, that for annuities purchased on February 8, 2006 and thereafter (the date of enactment of the Deficit Reduction Act of 2005), the state must be named as the remainder beneficiary of the annuity after your spouse or a minor or disabled child.

Beware of certain Medicaid planning risks

Medicaid planning is not without certain risks and drawbacks. In particular, you should be aware of look-back periods, possible disqualification for Medicaid, and estate recoveries.

When you apply for Medicaid, the state has the right to review, or look back, at your finances (and those of your spouse) for a period of months before the date you applied for assistance. In general, a 60-month look-back period exists for transfers of countable assets for less than fair market value. Transfers of countable assets for less than fair market value made during the look-back period will usually result in a waiting period before you can start to collect Medicaid. So, for example, if you give your house to your kids the year before you enter a nursing home, you'll be ineligible for Medicaid for quite some time. (A mathematical formula is used.)

Also, you should know that Medicaid planning is more effective in some states than in others. In addition, federal law encourages states to seek reimbursement from Medicaid recipients for Medicaid payments made on their behalf. This means that your state may be able to place a lien on your property while you are alive, or seek reimbursement from your estate after you die. Make sure to consult an attorney experienced with Medicaid planning and the laws in your state before taking any action.

Medicare

What is Medicare?

Medicare is a federal health insurance program created in 1965 to help pay medical costs incurred by people over the age of 65, people with certain disabilities, and people with end-stage renal disease. Coverage consisted of two parts: Part A (hospital insurance) and Part B (medical insurance). These parts together are known as Original Medicare. The 1997 Balanced Budget Act created Part C (originally called Medicare + Choice). Part C allowed private companies to offer Medicare benefits as well as benefits not offered by Medicare. In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act, the first major revision of the Medicare program since its creation, was signed into law. It preserved and strengthened the original plan, and offered important new prescription drug (Medicare Part D) and preventive benefits, as well as extra help to people with low incomes.

Medicare Part A (hospital insurance)

Generally called hospital insurance, Part A covers services associated with inpatient hospital care (i.e., the costs associated with an overnight stay in a hospital, skilled nursing facility, or psychiatric hospital, such as charges for the meals, hospital room, and nursing services). Part A also covers hospice care and home health care.

Medicare Part B (medical insurance)

Generally called medical insurance, Part B covers other medical care. Physician care--whether it was received while you were an inpatient at a hospital, at a doctor's office, or as an outpatient at a hospital or other health-care facility--is covered under Part B. In addition, ambulance service, laboratory tests, and physical therapy or rehabilitation services are covered. Part B also covers 100 percent of the cost of many preventive services and an annual wellness visit.

Medicare Part C (Medicare Advantage)

A Medicare Advantage plan is a private health-care plan that contracts with Medicare to provide Part A and Part B benefits. Most also offer prescription drug (Part D) coverage. Several types of Medicare Advantage plans may be available, including health maintenance organization (HMO) plans, preferred provider organization (PPO) plans, private fee-for-service (PFFS) plans, and special needs plans (SNPs). You can choose to enroll in either Original Medicare or a Medicare Advantage plan.

Medicare Part D

Medicare Part D covers the costs of prescription drugs. All Medicare beneficiaries are eligible to join a Medicare prescription drug plan offered by private companies or insurers that have been approved by Medicare.

Who administers the Medicare program?

The Centers for Medicare and Medicaid Services (CMS), a division of the U.S. Department of Health and Human Services, has overall responsibility for administering the Medicare program. While the Social Security Administration processes Medicare applications and claims, the CMS sets standards and policies, and manages the official government website for Medicare.

Tip: *Because the majority of Medicare beneficiaries also receive Social Security benefits, local Social Security offices also provide information about and assistance with Medicare. You can also access information by visiting ssa.gov (Social Security Administration site) and at medicare.gov, or by calling (800) Medicare.*

Who is eligible for coverage under Medicare?

Eligibility for Part A

You may be eligible for Medicare Part A if:

- You are age 65 or older and you are eligible for Social Security benefits

- You are a qualified Railroad Retirement beneficiary
- You are a dependent or a survivor of an individual age 65 or over who is entitled to Medicare Part A benefits or a dependent of an individual under age 65 who is entitled to Social Security retirement benefits OR
- You are under age 65 and disabled, and
- You have permanent kidney failure, requiring dialysis or a transplant
- You have been receiving Social Security benefits for at least 24 months because you meet the Social Security Administration's definition of permanent and total disability (i.e., you are unable to hold gainful employment in any job), or
- Under special circumstances, you are entitled to Railroad Retirement benefits because of disability

Tip: *Individuals who do not meet the eligibility requirements for premium-free hospital insurance can voluntarily enroll in Medicare Part A and pay a monthly premium. If you enroll in premium Medicare Part A, you must also enroll in Medicare Part B.*

Eligibility for Part B

You may be eligible for Medicare Part B if:

- You are entitled to Part A hospital insurance (by entitlement to Social Security or Railroad Retirement Act retirement or disability benefits, Medicare-qualified government employment, or end-stage renal disease benefits) and you are a citizen of the United States, or
- You are 65 or older, a U.S. resident, and either a U.S. citizen or an alien legally admitted for permanent residence who has continuously resided in the United States for at least five years prior to your enrollment month

Special eligibility requirements for federal, state, and local government employees

Federal employees who were originally exempt from Medicare because they were not covered under Social Security may qualify for Medicare. To compensate for their not having been eligible to accrue Social Security credits throughout their career, they may qualify for benefits with less than 40 credits or may be able to get their work credited for purposes of becoming Medicare eligible. Almost all federal employees hired after 1983 are covered under Medicare. State and local government employees who were originally exempt from Medicare may qualify depending on their state's agreement with Medicare. State and local employees hired after March 31, 1986, are covered under Medicare provisions.

Caution: *Unlike the state health insurance program, called Medicaid, eligibility for Medicare is not contingent on having low income and few assets. You may be eligible for coverage under both Medicare and Medicaid.*

How do you sign up for Medicare?

Enrollment is usually automatic

Any individual who receives Social Security benefits before age 65 or who applies for Social Security benefits at age 65 will be automatically enrolled in Medicare. However, if you retire after age 65, remember to enroll in Medicare at age 65 anyway, because your enrollment won't be automatic. Individuals who will be automatically enrolled in Medicare will receive notification by mail from the Social Security Administration, usually three months before your 65th birthday.

Tip: *You can decline to enroll in Medicare Part B. If you have been automatically enrolled in Part B, you will be notified that you have a certain amount of time to decline coverage.*

If you decline Part B coverage, will you have another chance to enroll later?

In your 65th year, you have seven months to enroll in Part B during the initial enrollment period, commencing at three months before your 65th birthday and lasting until 4 months after. If you decline Part B coverage that year, you can also enroll in later years during the annual general enrollment period from January 1 through March 31 each year. Coverage will begin in July of the year you enroll. However, the cost of the Part B monthly premium increases 10 percent for each 12-month period that you did not enroll although you were eligible, unless you did not enroll because you were still covered under an employer insurance plan. In that case, you need to enroll within eight months after termination of your coverage under your employer's plan (the special enrollment period).

How much does Medicare cost?

You generally do not pay a premium for enrolling in Medicare Part A. However, you will pay a premium for Part B.

Medicare premiums and deductibles change annually. Here's what you'll pay in 2018 for Parts A and B if you're enrolled in Original Medicare:

	Premium	Deductible	Coinsurance
Part A (hospital)	None for most people, but noneligible individuals pay up to $422 per month (if they have 39 or fewer quarters of Medicare-covered employment)	$1,340 per benefit period	$335 a day for the 61st to 90th day each benefit period; $670 a day for the 91st to 150th day for each lifetime reserve day (total of 60 lifetime reserve days); $167.50 a day for the 21st to 100th day each benefit period for skilled nursing facility care
Part B (medical)	The standard Part B premium amount is $134 (subject to an income-based adjustment). However, some people who get Social Security benefits will pay less than this amount ($130 on average). See below for more information.	$183 per year	After satisfying a deductible if one applies, you normally pay 20 percent of the approved amount for medical expenses (20 to 40 percent for outpatient mental health services, 20 percent for hospital charges for outpatient hospital services, nothing for laboratory services)

If you have your premiums deducted from your Social Security benefits, and the increase in your benefits for 2018 will not be enough to cover the Medicare Part B increase, then you may pay less than the standard Part B premium ($130 on average). Otherwise, you may pay the standard Part B premium of $134. You'll also pay the standard Part B premium of $134 (or higher) if:

- You enroll in Part B for the first time in 2018.
- You don't get Social Security benefits.
- You're directly billed for your Part B premiums.
- You have Medicare and Medicaid, and Medicaid pays your premiums.
- Your modified adjusted gross income as reported on your federal income tax return from two years ago is above a certain amount.*

The table below shows what you'll pay if you're in this group.

Beneficiaries who file an individual income tax return with income that is:	Beneficiaries who file a joint income tax return with income that is:	Beneficiaries who file an income tax return as married filing separately with income that is:	Monthly premium in 2018:
$85,000 or less	$170,000 or less	$85,000 or less	$134
Above $85,000 up to $107,000	Above $170,000 up to $214,000	N/A	$187.50
Above $107,000 up to $133,500	Above $214,000 up to $267,000	N/A	$267.90
Above $133,500 up to $160,000	Above $267,000 up to $320,000	N/A	$348.30
Above $160,000	Above $320,000	Above $85,000	$428.60

*Beneficiaries with higher incomes have paid higher Medicare Part B premiums since 2007. To determine if you're subject to income-related premiums, the SSA uses the most recent federal tax return provided by the IRS. Generally, the tax return you filed in 2017 (based on 2016 income) will be used to determine if you will pay an income-related premium in 2018. You can contact the

SSA at (800) 772-1213 if you have new information to report that might change the determination and lower your premium.

Since Original Medicare doesn't cover every type of medical care, and you'll have to pay deductibles and coinsurance, you may want to buy a Medicare supplemental insurance (Medigap) policy.

You must be enrolled in Parts A and B to get Medicare through a managed care plan, and if you choose a managed care plan under Part C, you may also have a monthly charge from the plan, and pay associated costs. If you're enrolled in a Medicare Advantage plan, you'll generally pay one monthly premium for that plan in addition to your Medicare Part B premium. Each Medicare Advantage plan has different premiums and costs for services, and coverage varies, so what you'll pay depends on the plan you have. Most Part D plans also charge a monthly premium. You may also need to satisfy an annual deductible and pay a share of your prescription costs.

How are Medicare payments determined?

The general rule is that Medicare pays for those costs it determines are reasonable and necessary for diagnosing or treating your illness or injury.

What are reasonable and necessary costs?

As a cost-control measure, Congress enacted complicated procedures for predetermining the dollar amounts Medicare will pay for the specific health care provided.

Part A costs are determined by calculating the average cost to diagnose and/or treat the principal diagnosis. Diagnoses are categorized into diagnosis-related groups, called DRGs. Part B costs are determined by calculating the cost of each variable in treating your illness or injury, such as the degree of expertise needed by the physician and the specific procedures used. Medicare will pay managed care plans directly under Part C. Costs may be adjusted for factors such as regional variations and the type of health-care facility providing the treatment.

Limits on charges under Medicare

If the health-care provider (whether it is a hospital, a physician, or other kind of provider) accepts Medicare assignments, the provider has agreed to accept the amount Medicare will pay as payment in full. Your Medicare carrier can give you the list of providers that accept Medicare assignments. It is illegal for a provider accepting Medicare assignment to charge you more than these amounts. Providers annually have the opportunity to sign a contract with Medicare that they will accept assignments or can also choose to accept Medicare assignment on an ad hoc basis.

In addition, even without assignment, a provider generally cannot charge more than 15 percent above the Medicare approved amount, except in three situations:

- You have agreed that neither you nor the provider will submit a claim to Medicare and you plan to pay out-of-pocket
- You are participating in Medicare's medical savings account plan and are using funds from your assets to pay for the services in question
- Medicare approves a higher amount because of extenuating circumstances in your case, as documented by your provider

The 15 percent limit only applies to certain services, not supplies or equipment.

If you are concerned that you are being billed in violation of Medicare regulations (e.g., that Medicare is being billed for services you did not receive or that a provider is performing unnecessary procedures), you can report it by calling the U.S. Department of Health and Human Services's toll-free fraud and abuse hotline at (800) HHS TIPS ((800) 447-8477).

How do you cover medical expenses over and above what Medicare pays?

Many individuals who are enrolled in Original Medicare purchase supplemental insurance known as Medigap to augment Medicare coverage. You should also understand the claims process and your rights if you disagree with the claims determination.

How Medicare claims are paid under Original Medicare

The claims process

Most health-care providers accept Medicare assignment and will submit your claims directly to Medicare. Providers who do not accept Medicare assignments are supposed to submit claims to Medicare for any Medicare-covered services and can't charge you for submitting a claim. If they don't submit a claim or if you have any questions, call (800) 633-4227. TTY users should call (877) 486-2048.

Every three months, you'll receive a Medicare Summary Notice (MSN) in the mail that includes all services and supplies that were billed to Medicare during that three-month period, what Medicare paid, and what you may owe the provider. You'll need to check this information against your own receipts and bills you've received from your health-care providers. You can also sign up to view your Medicare claims on-line.

Claims review and hearing procedures

If you disagree with a determination from Medicare that it will not pay a charge, you can appeal. The appeals process has five levels. There are similar, but separate, procedures for resolving claims under Part C. For more information on the claims or appeals process visit medicare.gov.

Medicaid Planning: Transfer of Assets

What is meant by a "transfer of assets"?

Assets can be transferred in a number of ways, such as by gift, by sale, by trade, or through a trust. Because eligibility for Medicaid is based on the level of your income and other resources, state Medicaid authorities are interested in knowing whether you have tried to circumvent the rules by transferring assets out of your name in order to qualify for Medicaid. Consequently, when you apply for Medicaid, the state has the right to examine your finances (and those of your spouse) for a certain period of time. This length of time is referred to as the look-back period for Medicaid, and it can go back as far as 60 months before the date you applied for Medicaid.

Caution: *Medicaid eligibility rules are subject to change. Seniors and their families should take no action without consulting a knowledgeable elder law attorney.*

Which transfers will trigger scrutiny by Medicaid authorities?

Only certain transfers are prohibited. In general, fair market transactions are above reproach; that is, if you receive something of equal fair market value in return for the assets you transferred away, the transaction is considered a legitimate one. For example, there would be nothing wrong with using cash from your savings account to purchase some stock. The stock will be added with your cash and other countable assets together when the Medicaid authorities consider your eligibility for Medicaid. If, however, you transfer certain assets for less than fair market value close to the time you apply for Medicaid, the state will presume that the transfer was made solely to qualify you for Medicaid. More specifically, a transfer of countable assets for less than fair market value within the look-back period is suspect and could subject you to penalties. Therefore, it would be a problem if you made a gift of $50,000 to your daughter two months before you applied for Medicaid.

Basically, countable assets may be defined as anything valuable you own that is not exempt by law or otherwise made inaccessible. Exempt assets, on the other hand, are those that do not affect your Medicaid eligibility. Each state composes a list of exempt assets, including such items as your principal residence, one automobile, and prepaid burial contracts. You can transfer most exempt assets at any time without creating a period of ineligibility.

Will a transfer of assets during the look-back period cause ineligibility for Medicaid?

When you apply for Medicaid, the state has the right to review or look back at your finances (and those of your spouse) for a period of months from the date you apply for assistance. For transfers made on or after February 8, 2006 (the date of enactment of the Deficit Reduction Act of 2005), the look-back period is 60 months for all transfers of countable assets. Transfers of countable assets for less than fair market value made during the look-back period (other than transfers to a spouse or a disabled, or a blind child or a disabled individual under age 65) will result in a waiting period or period or ineligibility before you can start to collect Medicaid benefits. If a transfer of assets takes place before the look-back period, however, the waiting period is inapplicable, and the transfer will not affect your Medicaid eligibility. The formula for determining the waiting period may be explained as the fair market value of transferred assets divided by the average monthly cost of nursing homes in your locale, the quotient representing the number of months you must wait before you can be eligible for certain Medicaid benefits.

Example(s): *Assume Alice gave $150,000 cash to her daughter. Two months later, she enters a nursing home (which charges a competitive rate of $6,000 per month) and applies for Medicaid. Alice will be ineligible to collect Medicaid benefits until 25 months have passed ($150,000 divided by $6,000 equals 25).*

Do hardship exceptions exist?

Denial of Medicaid eligibility due to a transfer of countable assets can cause an undue hardship for some people. Federal law (OBRA '93 and the Deficit Reduction Act of 2005) requires states to develop procedures for determining undue hardship in accordance with certain guidelines so that, in some cases, the state must grant Medicaid benefits to an applicant despite a disqualifying transfer.

Undue hardship exists when a denial of benefits would deprive a person of medical care to such an extent that his or her life or

health would be endangered. Undue hardship also exists when application of the transfer of assets rules would deprive the person of food, clothing, shelter, or other necessities of life. Although states have a great deal of flexibility in determining whether a particular situation constitutes undue hardship, they are obligated to provide the following information:

- A notice to recipients that an undue hardship exception exists
- A timely process to determine whether an undue hardship exception will be granted
- A process under which a denial of the exception can be appealed

Further, a facility may apply for a hardship exception on behalf of its residents with their consent, and a state may make payments to nursing facilities to hold beds for up to 30 days while a hardship exception is pending. For more information, contact your state's Medicaid office.

Comparing Long-Term Care Insurance Policies

Long-term care insurance (LTCI) policies come in many shapes and sizes. The number of options available can make it difficult to compare policies. Print this list of features and benefits, and refer to it as you compare LTCI policies. To find the right policy for you, make sure that you compare similar policies that combine the benefits and features you want.

Features and benefits to compare	Explanation
Financial rating of insurance company	Is the insurance company financially stable? To determine this, review ratings published by A. M. Best, Standard & Poor's, Fitch, and others. If you have questions about the ratings, ask your insurance professional for assistance.
Tax-qualified or nonqualified policy	Is part of your premium payment tax deductible? Most policies are eligible for favorable tax treatment, which can lower your cost.
Availability of multiple facilities for care	Does the policy cover nursing homes, assisted-living facilities, and home health care? Many policies will cover care in all three settings.
Benefit period	How long will benefits be paid? Common options are 2, 3, 4, 5, 6, 8, 10 years, or lifetime benefits. The longer the benefit period, the more you will pay.
Benefit amount	How much will the policy pay per day if you need care? The most common maximum benefit amounts are $50 to $350 per day.
Benefit method	How are benefits paid? If the reimbursement method is used, only actual expenses are covered and the provider is reimbursed directly. If the indemnity method is used, the daily benefit amount specified in the contract is paid directly to the insured.
Pooled benefit	If the policy uses the reimbursement method of claims payment, does it include a pooled benefit feature? Under the reimbursement method, only your actual expenses are covered. If your actual expenses are less than your coverage amount, the pooled benefit feature allows you to save unused daily benefits for later. Without it, you forfeit any unused benefits.
Elimination (waiting) period	How long will you have to wait before benefits begin once you become medically eligible? Common options are 0, 30, 60, 90, 100, 180, or 365 days. The shorter the elimination period, the more you will pay.
Recurrent claims	What happens if you recover but then need care again? Some policies require only one waiting period during the life of the policy, while others require a new waiting period when no benefit has been received for a period of time, usually 180 days.
Waiver of premium	Will you need to keep paying your LTCI premiums once you're receiving care? A waiver of premium option provides that no premium payments will be due while you are receiving benefits.
Activities of daily living (ADLs) requirement	What will trigger your eligibility for benefits? Find out how many ADLs (e.g., eating, bathing, and dressing) you must be unable to perform without assistance before a claim can be made. The fewer required the better. Available options range from two or three ADLs out of five or six.
Gatekeepers	What conditions must be satisfied in order to qualify for benefits? For example, you may need to be hospitalized for three days, receive paid professional services during the elimination period, and use caregivers who have certain credentials.

Inflation options	Will your benefit keep pace with the cost of living? A variety of options are available. No inflation protection means that your benefit amount will not increase, regardless of the increases in the cost of care. If you do not purchase inflation protection, you may be offered the opportunity to purchase increased benefits for an additional premium based on the increase in the cost of living at periodic intervals, such as every year or every three years. Other typical options include 5% simple or 5% compounded annual increases in benefit amounts. These options may allow for unlimited increases or an increase capped at two or three times the original benefit.
Reduced paid-up option	Does the policy include a reduced paid-up option? If so, the policy will pay some benefits even if you decide to stop paying the premiums.
Return of premium at death option	Does the policy include a return of premium at death option? This refunds premiums if you die prematurely, but it generally applies only for deaths that occur before age 70.
Bed reservation benefit	Does the policy include a bed reservation benefit? This option will hold your place at the nursing home if you a have a hospital stay.
Other benefits	Does the policy offer any nonstandard benefits? These include respite care and care advisory services.
Exclusions to the contract	What coverage exclusions apply? Examples include pre-existing conditions excluded for a period of time after your policy is issued, and mental or emotional disorders without an organic disease.
Premium per $10/day of benefit	What premium will you pay? The biggest factor in determining premiums is age, but the options you choose count, too. Compare the cost of each option for each policy, and not just the total premium that includes all of the options you want.
Spousal discounts	Will you receive a discount if both you and your spouse buy a policy? Discounts of 10% to 20% are sometimes available to one or both spouses if both buy a policy.

Purchase of Exempt Assets

What is it?

What is meant by the phrase "purchase of exempt assets?"

To qualify for Medicaid, both your income and the value of your other assets must fall below certain limits, which vary from state to state. In determining your eligibility for Medicaid, a state may add up only your countable resources; it cannot consider income and assets that are exempt under the law. Briefly, countable assets may be defined as anything valuable you own that is not exempt by your state's law or otherwise made inaccessible to you. Consequently, it has become standard practice for a Medicaid applicant to use countable resources to purchase exempt assets.

Which assets are exempt?

Exempt assets are those that do not affect your eligibility for Medicaid. (In Medicaid lingo, exempt assets are not countable.) Under federal guidelines, each state composes a list of exempt assets, which include the following:

- Equity in your principal home up to your state's exempt asset limit (all equity is exempt if you, your spouse, or your minor, disabled, or blind child resides there)
- Household furnishings, jewelry, and personal effects (though some states limit these items)
- Burial plots for the Medicaid applicant and immediate members of family
- Prepaid, noncancelable burial contracts
- One automobile (for use by you and your family)
- Term life insurance policies
- Cash value of life insurance policies, provided the face value does not exceed $1,500

Example(s): *If Medicaid applicant George and his wife, Martha, own a principal home worth $400,000, one car, and a term life insurance policy of $300,000, then none of these assets will affect George's eligibility for Medicaid--they are all exempt.*

How is this strategy useful in Medicaid planning?

By spending countable assets (such as cash) on exempt assets (like a car), you are decreasing the level of your countable assets, which increases your chances of qualifying for Medicaid. At the same time, you are improving the quality of life for your at-home spouse. He or she can enjoy a new car, a paid-off mortgage on the principal home, or a new roof on the house. Clearly, however, this strategy is most useful if you have a spouse or other eligible family member residing in your family home.

What, specifically, should you purchase?

Basically, you should review your state's list of exempt assets and purchase any items you find useful. Moreover, you should pay off your debts. Remember, a transfer of assets is not prohibited if you are getting something of equal fair market value in return for the assets you have transferred. You may wish to consider spending your countable assets in the following manner:

Buy a home

Since your principal residence is an exempt asset while you live there or if you intend to return there, or if you're married and your spouse resides there, you should consider purchasing a house or a condominium if you presently rent. It makes no difference whether the house costs $45,000 or $245,000. You'll want to make sure that title to the house stands in the name of the healthy spouse.

This is not the best asset for everyone, however. For instance, home ownership (with all of its accompanying repairs and upkeep) may be impractical for an elderly spouse whose partner is in a nursing home. Also, it may or may not be the right move if you are single.

Make home improvements and repairs

You can use countable assets to improve your exempt home in a number of ways, including constructing an addition, repairing the driveway, replacing the roof, buying a new furnace, or adding handicap ramps.

Example(s): *Assume Nicholas and Sandra are an elderly married couple with joint assets of $140,000, plus a house. When Nicholas enters a nursing home, the state determines that Sandra can keep the house (since it is exempt and she resides there) as well as one-half of the remaining assets (or $70,000). Because Nicholas owns $70,000 worth of countable assets, however, he will not qualify for Medicaid until he has "spent down" this money to $2,000, which is the threshold amount of assets his state allows for Medicaid applicants.*

Example(s): *Instead of using his $70,000 to pay nursing home bills, Nicholas can give an amount to his wife up to the limit of their state's maximum community spouse resource allowance and then he can use the remainder to add aluminum siding to the family house, add insulation, renovate the kitchen, add handicap ramps, and tend to the landscaping. When the money is spent, he can apply for Medicaid. Thus, money that would have been consumed by nursing home bills can, instead, be sheltered in the house.*

Pay off your debts

Paying off your debts does not violate the transfer of assets rule because you receive something of fair value (i.e., forgiveness of a legal debt) in exchange for the payment. Therefore, you can use your countable assets to pay off your mortgage, your automobile loan, your credit card, and other debts. This is a wise move, because the Medicaid authorities will not net or subtract your debts from your assets when they determine the value of your countable assets.

Purchase a car and household goods

Household furnishings, personal effects, and one automobile are exempt assets. Therefore, you should consider using your countable assets to buy a new car, a new refrigerator, a new stove, or like items. (Note, however, that some states impose a limit on the value of a car that may be considered exempt.)

Be careful not to buy outrageous items, however, like a $20,000 oriental rug or a $50,000 diamond ring. The state will view such purchases with suspicion and may reclassify them as disqualifying transfers.

Prepay burial and funeral costs

Burial and funeral expenses are inevitable (and expensive), so you may wish to consider prepaying these items with your countable resources. Federal regulations allow a burial space (and gravestone or marker) to be purchased for the Medicaid applicant and the members of his or her immediate family. Additionally, some states allow you to enter into a prepaid, noncancelable burial contract (including funeral service) with a specific funeral home. Of these states, some impose a limit on the amount of money that can be set aside for this purpose, while other states allow a prepaid funeral contract in any amount to be exempted.

Several states also permit the Medicaid applicant (and spouse, if any) to set aside up to a specified amount in a bank account expressly reserved for funeral, burial, and related expenses which are not covered by a prepaid funeral contract.

When can it be used?

You want to preserve otherwise countable assets and you anticipate the need for long-term care

There are really no prerequisites that must be met. Purchase of exempt assets is a very useful strategy to help you qualify for Medicaid and/or to provide a higher standard of living for the at-home spouse.

Strengths

Helps Medicaid applicant qualify for Medicaid

In determining your eligibility for Medicaid, a state can consider only your countable resources; it cannot consider assets that are exempt under the law. Usually, your countable resources must be spent down to the threshold level set by your state before you can qualify for Medicaid. You can qualify for Medicaid much more quickly by spending your countable resources on exempt assets.

Potentially preserves assets for your loved ones

Under normal circumstances, your excess countable resources would be consumed by the nursing home to pay for your medical care. Purchasing exempt assets with countable resources, however, serves to potentially preserve assets and improve the quality of life for your spouse (if any).

Avoids Medicaid ineligibility period

Often, transferring your countable assets in order to qualify for Medicaid subjects you to various penalties, including a period of ineligibility before you can collect Medicaid benefits (the state has the right to look back at your finances for a period of 60 months to see if any transfers were made for less than fair market value that might affect your eligibility for Medicaid). A purchase of exempt assets, however, is an exception to this rule. By law, each state must allow you to spend your money on certain specified exempt assets; there can be no penalty imposed.

Tradeoffs

Strategy not quite as useful if you have limited means

If you have substantial resources, you can benefit greatly by purchasing a house, replacing a roof, adding vinyl siding, or buying a furnace. On the other hand, if you're very elderly, rent an apartment, no longer drive a car, and don't have much in the way of excess resources, a purchase of exempt assets may not be as beneficial.

Strategy not quite as useful if you're single

Assume you're single, have just become institutionalized in a nursing home, have $50,000 worth of excess countable resources, and wish to apply for Medicaid. Your house is not considered an exempt asset, since you no longer reside there and you have no spouse (or minor, disabled, or blind child; a sibling with an equity interest in the home who has been residing there at least one year before your institutionalization; or a child who has been living in the home with you for least two years and who provided care to you that allowed you to reside in the home) living there. Chances are, you are no longer able to drive, so you have no need for a car. What's left? Well, you can prepay your funeral and burial costs and perhaps buy a few personal effects. It's easy to see that single people do not benefit quite as much from the strategy of purchasing exempt assets as do married couples.

How to do it

If you are interested in using your countable resources to purchase exempt assets, there are a couple of steps you should follow:

Gather your Medicaid eligibility information before visiting an attorney

- Prepare a list of all your assets (and those of your spouse), indicating how title is held, the tax basis, and how much you paid for the asset.
- Prepare a list of your (and spouse's) income from all sources.
- Indicate whether your resources are, for Medicaid purposes, exempt, not exempt, or inaccessible.
- Prepare a list of all assets transferred within the last five years, whether by way of gift, trust, or otherwise. Indicate date of transfer, transferee, purpose, and consideration (what you received in return).
- If you are considering purchasing a funeral contract, burial plot, or headstone, obtain information on the choices and costs of these items.

Consult a Medicaid attorney

In recent years, the Medicaid laws have undergone a number of changes. Indeed, because certain planning vehicles have been eliminated and most rules tightened, it is reasonable to expect that further changes will occur in the years ahead. It is vital, therefore, to consult with an attorney experienced with Medicaid planning.

An attorney will advise you of your options, make recommendations, and ensure that you spend your countable assets in the most advantageous manner.

Tax considerations

Income tax

Essentially, there are no tax ramifications regarding your purchase of most exempt assets, such as prepaid burial plots, household furnishings, or personal effects. The expenses of purchasing these items are not deductible. However, itemized deduction issues may arise upon the purchase of a new house..

Questions & Answers

You're a widow who has just entered a nursing home. You are no longer able to drive a car and don't own a house--you had been renting for years. The problem is, you must spend down $15,000 before you can qualify for Medicaid. You don't want the nursing home to get that money. Is there any way you can help your daughter with it?

Yes. You can start by prepaying for your funeral and burial. That could use up about $4,500 or more. Next, you can prepay her funeral and burial. Finally, you may wish to buy a car for your daughter (to make it easier for her to visit you). Remember, exempt assets include burial plots for you and your family members and one automobile that can be used by you or by the members of your immediate family.

You live in a nursing home and have just applied for Medicaid. You know that your house would be exempt if you resided there or if your spouse (or minor, disabled, or blind child) lived there. Unfortunately, you are a widower, and your children are adults who live in homes of their own. What will happen to your house?

If you're a Medicaid recipient and have become a permanent resident of a nursing home, federal law allows a lien to be placed on your home. When you die, the state can seek reimbursement to recover Medicaid benefits paid on your behalf. State practice does vary, however, so check the laws of your state.

Health Insurance in Retirement

At any age, health care is a priority. When you retire, however, you will probably focus more on health care than ever before. Staying healthy is your goal, and this can mean more visits to the doctor for preventive tests and routine checkups. There's also a chance that your health will decline as you grow older, increasing your need for costly prescription drugs or medical treatments. That's why having health insurance is extremely important.

Retirement--your changing health insurance needs

If you are 65 or older when you retire, your worries may lessen when it comes to paying for health care--you are most likely eligible for certain health benefits from Medicare, a federal health insurance program, upon your 65th birthday. But if you retire before age 65, you'll need some way to pay for your health care until Medicare kicks in. Generous employers may offer extensive health insurance coverage to their retiring employees, but this is the exception rather than the rule. If your employer doesn't extend health benefits to you, you may need to buy a private health insurance policy (which may be costly), extend your employer-sponsored coverage through COBRA, or purchase an individual health insurance policy through either a state-based or federal health insurance Exchange Marketplace.

But remember, Medicare won't pay for long-term care if you ever need it. You'll need to pay for that out of pocket or rely on benefits from long-term care insurance (LTCI) or, if your assets and/or income are low enough to allow you to qualify, Medicaid.

More about Medicare

As mentioned, most Americans automatically become entitled to Medicare when they turn 65. In fact, if you're already receiving Social Security benefits, you won't even have to apply--you'll be automatically enrolled in Medicare. However, you will have to decide whether you need only Part A coverage (which is premium-free for most retirees) or if you want to also purchase Part B coverage. Part A, commonly referred to as the hospital insurance portion of Medicare, can help pay for your home health care, hospice care, and inpatient hospital care. Part B helps cover other medical care such as physician care, laboratory tests, and physical therapy. You may also choose to enroll in a managed care plan or private fee-for-service plan under Medicare Part C (Medicare Advantage) if you want to pay fewer out-of-pocket health-care costs. If you don't already have adequate prescription drug coverage, you should also consider joining a Medicare prescription drug plan offered in your area by a private company or insurer that has been approved by Medicare.

Unfortunately, Medicare won't cover all of your health-care expenses. For some types of care, you'll have to satisfy a deductible and make co-payments. That's why many retirees purchase a Medigap policy.

What is Medigap?

Unless you can afford to pay for the things that Medicare doesn't cover, including the annual co-payments and deductibles that apply to certain types of care, you may want to buy some type of Medigap policy when you sign up for Medicare Part B. There are 10 standard Medigap policies available. Each of these policies offers certain basic core benefits, and all but the most basic policy (Plan A) offer various combinations of additional benefits designed to cover what Medicare does not. Although not all Medigap plans are available in every state, you should be able to find a plan that best meets your needs and your budget.

When you first enroll in Medicare Part B at age 65 or older, you have a six-month Medigap open enrollment period. During that time, you have a right to buy the Medigap policy of your choice from a private insurance company, regardless of any health problems you may have. The company cannot refuse you a policy or charge you more than other open enrollment applicants.

Thinking about the future--long-term care insurance and Medicaid

The possibility of a prolonged stay in a nursing home weighs heavily on the minds of many older Americans and their families. That's hardly surprising, especially considering the high cost of long-term care.

Many people in their 50s and 60s look into purchasing LTCI. A good LTCI policy can cover the cost of care in a nursing home, an assisted-living facility, or even your own home. But if you're interested, don't wait too long to buy it--you'll need to be in good health. In addition, the older you are, the higher the premium you'll pay.

You may also be able to rely on Medicaid to pay for long-term care if your assets and/or income are low enough to allow you to qualify. But check first with a financial professional or an attorney experienced in Medicaid planning. The rules surrounding this issue are numerous and complicated and can affect you, your spouse, and your beneficiaries and/or heirs.

Understanding Long-Term Care Insurance

It's a fact: People today are living longer. Although that's good news, the odds of requiring some sort of long-term care increase as you get older. And as the costs of home care, nursing homes, and assisted living escalate, you probably wonder how you're ever going to be able to afford long-term care. One solution that is gaining in popularity is long-term care insurance (LTCI).

What is long-term care?

Most people associate long-term care with the elderly. But it applies to the ongoing care of individuals of all ages who can no longer independently perform basic activities of daily living (ADLs)--such as bathing, dressing, or eating--due to an illness, injury, or cognitive disorder. This care can be provided in a number of settings, including private homes, assisted-living facilities, adult day-care centers, hospices, and nursing homes.

Why you need long-term care insurance (LTCI)

Even though you may never need long-term care, you'll want to be prepared in case you ever do, because long-term care is often very expensive. Although Medicaid does cover some of the costs of long-term care, it has strict financial eligibility requirements--you would have to exhaust a large portion of your life savings to become eligible for it. And since HMOs, Medicare, and Medigap don't pay for most long-term care expenses, you're going to need to find alternative ways to pay for long-term care. One option you have is to purchase an LTCI policy.

However, LTCI is not for everyone. Whether or not you should buy it depends on a number of factors, such as your age and financial circumstances. Consider purchasing an LTCI policy if some or all of the following apply:

- You are between the ages of 40 and 84
- You have significant assets that you would like to protect
- You can afford to pay the premiums now and in the future
- You are in good health and are insurable

How does LTCI work?

Typically, an LTCI policy works like this: You pay a premium, and when benefits are triggered, the policy pays a selected dollar amount per day (for a set period of time) for the type of long-term care outlined in the policy.

Most policies provide that certain physical and/or mental impairments trigger benefits. The most common method for determining when benefits are payable is based on your inability to perform certain activities of daily living (ADLs), such as eating, bathing,

dressing, continence, toileting (moving on and off the toilet), and transferring (moving in and out of bed). Typically, benefits are payable when you're unable to perform a certain number of ADLs (e.g., two or three).

Some policies, however, will begin paying benefits only if your doctor certifies that the care is medically necessary. Others will also offer benefits for cognitive or mental incapacity, demonstrated by your inability to pass certain tests.

Comparing LTCI policies

Before you buy LTCI, it's important to shop around and compare several policies. Read the Outline of Coverage portion of each policy carefully, and make sure you understand all of the benefits, exclusions, and provisions. Once you find a policy you like, be sure to check insurance company ratings from services such as A. M. Best, Moody's, and Standard & Poor's to make sure that the company is financially stable.

When comparing policies, you'll want to pay close attention to these common features and provisions:

- Elimination period: The period of time before the insurance policy will begin paying benefits (typical options range from 20 to 100 days). Also known as the waiting period.
- Duration of benefits: The limitations placed on the benefits you can receive (e.g., a dollar amount such as $150,000 or a time limit such as two years).
- Daily benefit: The amount of coverage you select as your daily benefit (typical options range from $50 to $350).
- Optional inflation rider: Protection against inflation.
- Range of care: Coverage for different levels of care (skilled, intermediate, and/or custodial) in care settings specified in policy (e.g., nursing home, assisted living facility, at home).
- Pre-existing conditions: The waiting period (e.g., six months) imposed before coverage will go into effect regarding treatment for pre-existing conditions.
- Other exclusions: Whether or not certain conditions are covered (e.g., Alzheimer's or Parkinson's disease).
- Premium increases: Whether or not your premiums will increase during the policy period.
- Guaranteed renewability: The opportunity for you to renew the policy and maintain your coverage despite any changes in your health.
- Grace period for late payment: The period during which the policy will remain in effect if you are late paying the premium.
- Return of premium: Return of premium or nonforfeiture benefits if you cancel your policy after paying premiums for a number of years.
- Prior hospitalization: Whether or not a hospital stay is required before you can qualify for LTCI benefits.

When comparing LTCI policies, you may wish to seek assistance. Consult a financial professional, attorney, or accountant for more information.

What's it going to cost?

There's no doubt about it: LTCI is often expensive. Still, the cost of LTCI depends on many factors, including the type of policy that you purchase (e.g., size of benefit, length of benefit period, care options, optional riders). Premium cost is also based in large part on your age at the time you purchase the policy. The younger you are when you purchase a policy, the lower your premiums will be.

Protecting At-Home Spouse

What are the basic Medicaid rules pertaining to spouses?

With respect to a married couple, financial protection of the healthy or at-home spouse is always an important concern. A general overview of the Medicaid rules pertaining to married couples is helpful before considering the applicable transfer strategies.

- Eligibility for Medicaid is based on the amount of your income and other resources. With respect to a married couple, each spouse is entitled to his or her own periodic income; the healthy spouse is under no obligation to contribute to the institutionalized spouse's medical care.
- A different rule applies to assets, however. When one spouse enters a nursing home and applies for Medicaid, the couple's assets must be totaled to determine what portion the noninstitutionalized spouse may keep. After this spousal resource allowance has been determined, the Medicaid applicant must transfer assets representing the amount of the allowance to the at-home spouse.

Example(s): *Assume George enters a nursing home on February 2 and applies for Medicaid three months later on May 1. He and his wife, Martha, have combined assets of $24,000--$18,000 of which is held in his IRA. Medicaid will take a snapshot view of their combined assets on February 2 (the date of institutionalization) in order to determine the spousal resource allowance. Martha will be entitled to one-half of the assets up to a minimum established by their state.*

After the transfer of assets (if any), the institutionalized spouse must spend down most of his or her portion of the assets on his or her own medical care, assuming his or her state allows a spend-down.

What planning strategies exist to help the at-home spouse?

Because Medicaid pools together a married couple's assets when determining the eligibility of one spouse for Medicaid, Medicaid permits unlimited transfers of these assets between the husband and wife without penalty, which creates planning opportunities.

- An important loophole exists in that the healthy spouse can take jointly owned, countable assets and purchase a single premium immediate annuity for the benefit of him- or herself alone. In effect, the healthy spouse is converting countable assets into an income stream, and, as mentioned before, each spouse is entitled to all of his or her own income.
- Another option involves exempt assets and transfers for fair market value, discussed under the section Purchase of Exempt Assets . Briefly, a spouse entering a nursing home can use otherwise countable assets to purchase exempt assets, to pay off debts, and to make household repairs. Each state composes a list of exempt assets, meaning those assets that will not affect a person's eligibility for Medicaid. This list will typically include such items as the principal home, one automobile, and prepaid burial arrangements. By spending otherwise countable assets in this fashion, you can: (1) decrease the level of your countable assets in order to increase your chances of qualifying for Medicaid, and (2) protect the community spouse by lowering his or her debt level and increasing the value and safety of the family home.
- Third, it's vital to recall that transfer of the family home between spouses is allowable. Such a transfer is not subject to a look-back period or to any other penalties. Therefore, if a husband becomes institutionalized, he can deed his interest in the house to his wife (so that it will stand in her name alone). She can then create a will, naming her children (or anyone other than the institutionalized spouse) as beneficiaries.

Caution: *Absent such a transfer of a jointly owned home, the house could be taken by the state. If the healthy spouse unexpectedly died before the institutionalized spouse, the house would belong to the institutionalized spouse and the state could place a lien on it for reimbursement for Medicaid benefits paid. Further, although interspousal transfers are fine, bear in mind that transfers of resources for less than fair market value by either spouse to a third party are subject to transfer penalties, no matter which spouse is institutionalized when applying for Medicaid.*

Medicare Figures At-a-Glance

	2017	2018
Medicare monthly premium amounts		
Part A (hospital insurance) premium		
Individuals with 40 or more quarters of Medicare-covered employment	$0	$0
Individuals with less than 40 quarters of Medicare-covered employment who are not otherwise eligible for premium-free hospital insurance	Up to $413	Up to $422
Part B (medical insurance) premium per month (standard)	$109 / $134[1]	$130 / $134[1]
Original Medicare plan deductible and coinsurance amounts		
Part A (hospital insurance)		
Deductible per benefit period	$1,316	$1,340
Coinsurance per day for 61st to 90th day of each benefit period	$329	$335
Coinsurance per day for 91st to 150th day for each lifetime reserve day (total of 60 lifetime reserve days--nonrenewable)	$658	$670
Skilled nursing facility coinsurance per day for 21st to 100th day of each benefit period	$164.50	$168.00
Part B (medical insurance) annual deductible		
Individual pays 20 percent of the Medicare-approved amount for services after deductible is met	$183	$183

[1]The standard Part B premium amount is $134 (or higher depending on your income). However, some people who get Social Security benefits will pay less than this amount ($109 on average in 2017; $130 on average in 2018).

Tips for Caregivers

This document is no longer available

Caring for Your Aging Parents

Caring for your aging parents is something you hope you can handle when the time comes, but it's the last thing you want to think about. Whether the time is now or somewhere down the road, there are steps that you can take to make your life (and theirs) a little easier. Some people live their entire lives with little or no assistance from family and friends, but today Americans are living longer than ever before. It's always better to be prepared.

Mom? Dad? We need to talk

The first step you need to take is talking to your parents. Find out what their needs and wishes are. In some cases, however, they may be unwilling or unable to talk about their future. This can happen for a number of reasons, including:

- Incapacity
- Fear of becoming dependent
- Resentment toward you for interfering
- Reluctance to burden you with their problems

If such is the case with your parents, you may need to do as much planning as you can without them. If their safety or health is in danger, however, you may need to step in as caregiver. The bottom line is that you need to have a plan. If you're nervous about talking to your parents, make a list of topics that you need to discuss. That way, you'll be less likely to forget anything. Here are some things that you may need to talk about:

- Long-term care insurance: Do they have it? If not, should they buy it?
- Living arrangements: Can they still live alone, or is it time to explore other options?
- Medical care decisions: What are their wishes, and who will carry them out?
- Financial planning: How can you protect their assets?
- Estate planning: Do they have all of the necessary documents (e.g., wills, trusts)?
- Expectations: What do you expect from your parents, and what do they expect from you?

Preparing a personal data record

Once you've opened the lines of communication, your next step is to prepare a personal data record. This document lists information that you might need in case your parents become incapacitated or die. Here's some information that should be included:

- Financial information: Bank accounts, investment accounts, real estate holdings
- Legal information: Wills, durable power of attorneys, health-care directives
- Funeral and burial plans: Prepayment information, final wishes
- Medical information: Health-care providers, medication, medical history
- Insurance information: Policy numbers, company names
- Advisor information: Names and phone numbers of any professional service providers
- Location of other important records: Keys to safe-deposit boxes, real estate deeds

Be sure to write down the location of documents and any relevant account numbers. It's a good idea to make copies of all of the documents you've gathered and keep them in a safe place. This is especially important if you live far away, because you'll want the information readily available in the event of an emergency.

Where will your parents live?

If your parents are like many older folks, where they live will depend on how healthy they are. As your parents grow older, their health may deteriorate so much that they can no longer live on their own. At this point, you may need to find them in-home health care or health care within a retirement community or nursing home. Or, you may insist that they come to live with you. If money is an issue, moving in with you may be the best (or only) option, but you'll want to give this decision serious thought. This decision will impact your entire family, so talk about it as a family first. A lot of help is out there, including friends and extended family. Don't be afraid to ask.

Evaluating your parents' abilities

If you're concerned about your parents' mental or physical capabilities, ask their doctor(s) to recommend a facility for a geriatric assessment. These assessments can be done at hospitals or clinics. The evaluation determines your parents' capabilities for day-to-day activities (e.g., cooking, housework, personal hygiene, taking medications, making phone calls). The facility can then refer you and your parents to organizations that provide support.

If you can't be there to care for your parents, or if you just need some guidance to oversee your parents' care, a geriatric care manager (GCM) can also help. Typically, GCMs are nurses or social workers with experience in geriatric care. They can assess your parents' ability to live on their own, coordinate round-the-clock care if necessary, or recommend home health care and other agencies that can help your parents remain independent.

Get support and advice

Don't try to care for your parents alone. Many local and national caregiver support groups and community services are available to help you cope with caring for your aging parents. If you don't know where to find help, contact your state's department of eldercare services. Or, call (800) 677-1116 to reach the Eldercare Locator, an information and referral service sponsored by the federal government that can direct you to resources available nationally or in your area. Some of the services available in your community may include:

- Caregiver support groups and training
- Adult day care
- Respite care
- Guidelines on how to choose a nursing home
- Free or low-cost legal advice

Once you've gathered all of the necessary information, you may find some gaps. Perhaps your mother doesn't have a health-care directive, or her will is outdated. You may wish to consult an attorney or other financial professional whose advice both you and your parents can trust.

How does Medicare Advantage work?

Answer:

Medicare Advantage permits Medicare beneficiaries to receive health care through managed care plans (e.g., HMOs) and private fee-for-service plans. When you join a Medicare Advantage plan (also known as Medicare Part C), you may be able to save money on your health-care costs, and you may get additional benefits not found in original Medicare. To enroll in Medicare Advantage, you must be covered under both Medicare Part A and Medicare Part B.

Unfortunately, not all plans are available in all areas. To learn about what options are available in your region, call (800) MEDICARE or visit the Medicare website at www.medicare.gov.

How do I enroll in Medicare?

Some people automatically get Medicare Part A and Part B (Original Medicare). You'll be automatically enrolled in Original Medicare when you turn 65 if you've already been receiving Social Security or Railroad Retirement Board benefits for at least four months. If you get disability benefits from Social Security or certain disability benefits from the Railroad Retirement Board, you'll automatically get Medicare Part A and Part B after 24 months. The Social Security Administration will notify you that you're being enrolled, and you will receive your Medicare card in the mail.

Although there's no cost to enroll in Medicare Part A (Hospital Insurance), you'll pay a premium to enroll in Medicare Part B (Medical Insurance). If you've been automatically enrolled in Part B, you'll be notified that you have a certain amount of time after your enrollment date to decline coverage.

If you decide to postpone applying for Social Security past your 65th birthday, you can still enroll in Medicare when you turn 65. The Social Security Administration suggests that you call (800) 772-1213 at least three months before you turn 65 to discuss your options. You can apply for Medicare online at the Social Security website, ssa.gov, in person at a local office, or by phone.

If I'm covered by Medicare, should I have additional health insurance?

You may need to purchase health insurance to supplement your Original Medicare coverage, because Medicare generally won't cover all of your medical expenses. Usually, you'll have to satisfy a deductible before Medicare pays anything, and you'll also pay a co-payment when you visit a physician or are admitted to the hospital.

Fortunately, you can buy supplemental insurance from private companies that will help you plug the gaps in your Medicare coverage. These Medigap plans are regulated and standardized by the federal government. There are 10 different kinds of plans, although your state may not offer all of them (and three states, Massachusetts, Minnesota, and Wisconsin, have their own standardized plans). If premium cost is a concern, you can purchase lower-cost Medigap plans that only partially cover Medicare deductibles, co-payments and coinsurance costs. Conversely, if you want extensive coverage and don't mind paying more for it, you can purchase a Medigap plan that covers most of the deductibles, co-payments, and extra charges associated with Medicare. You can compare plans at the Health Care Financing Administration's website (medicare.gov).

Whatever plan you choose, you have the right to cancel it within a certain amount of time (usually 30 days, sometimes longer) if you don't like the policy after you buy it. In addition, the policy must be guaranteed renewable and cannot duplicate existing coverage, including Medicare.

Another way to supplement Medicare is to keep in effect any employer-sponsored health-care insurance you have. Depending on the type of coverage you have, and whether you're retired, one plan will pay your health-care costs first, and the other plan will cover some or all of the remaining costs. To make sure claims are properly paid, let your health provider know when you have health insurance in addition to Medicare.

Note that if you have a Medicare Advantage (Part C) plan, you don't need a Medigap plan, and it's illegal for anyone to sell you one unless you're in the process of switching back to Original Medicare.

Is there such a thing as nursing home insurance?

Answer:

Insurance that pays for expenses related to long-term (custodial) care comes in many shapes and sizes. Some insurance policies only pay for care provided in a nursing home or assisted living facility, and does not pay for care provided at adult day care centers or in your home. These types of plans are called facilities-only plans or nursing home insurance.

Comprehensive plans, on the other hand, not only cover long-term care provided in nursing homes or assisted living facilities, but these policies also pay for services rendered in a hospice facility, adult day care center, and even at home. Generally, facilities-only plans usually cost less than comprehensive policies.

What is Medigap?

Answer:

Medigap is health insurance that supplements the benefits covered under Medicare. It also fills in some of the gaps left by Medicare, such as your deductible and coinsurance contributions. Medigap policies are sold by private insurance companies, and must be clearly identified as "Medicare Supplemental Insurance." Currently, 10 standardized plans are available (Plans A-D, Plans F and G, and Plans K-N) (except in Massachusetts, Minnesota, and Wisconsin, which have their own standardized plans). Each provides a different level of coverage, but not all plans are available in all states.

Plan A covers the following basic benefits:

- Part A coinsurance costs up to 365 extra days of hospital care once Medicare benefits are used up
- Part B coinsurance or co-payment
- The first three pints of blood you may need in a year (Medicare pays for any additional blood)
- Part A hospice care coinsurance or co-payment

Other plans cover the same basic benefits, plus some extra benefits that include different combinations of the following:

- Coverage of your Part A deductible
- Coverage of your Part B deductible
- Coverage of the daily co-payment requirement for skilled nursing care
- Medically necessary emergency care needed during the first two months of a trip outside the United States
- Medicare Part B excess charges (i.e., the difference between your doctor's fee and Medicare's allowance)
- Medicare preventive care Part B coinsurance costs

Two plans, Plans K and L may have lower premium costs than other Medigap plans because they require you to pay a portion of Part B coinsurance or co-payment costs, and Part A deductible and hospice care coinsurance or co-payment costs. However, they provide protection against catastrophic illnesses by limiting your annual out-of-pocket expenses.

Some of the benefits not covered by Medigap include long-term nursing home care, and vision and dental care. Medigap will follow Medicare in excluding what is unnecessary or experimental.

If you are covered by your former employer's health insurance plan, you may not need Medigap.

IMPORTANT DISCLOSURES

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